

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
CALIFORNIA PATIENT DISCHARGE DATA REPORTING MANUAL, THIRD EDITION
For Discharge Data for the Years 1999 and 2000

EXTERNAL CAUSE OF INJURY

Section 97227

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for discharges with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported only for the first inpatient hospitalization during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect first diagnosed and/or treated during the current inpatient hospitalization.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:

E-CODES					
18. PRINCIPAL	E				
19. OTHER	E				
	E				
	E				
	E				

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Reporting Requirements:

- If the external cause of injury, poisoning, or adverse effect was reported on a first inpatient discharge data record to OSHPD, it should not be reported again for the same patient.
- If the external cause of injury, poisoning, or adverse effect was previously treated only on an outpatient basis (e.g., emergency room, ambulance, outpatient clinic, physician's office), the external cause of injury, poisoning, or adverse effect must be reported during the first inpatient hospitalization for the injury, poisoning, or adverse effect.
- Reporting medical/surgical misadventure and abnormal reaction codes (categories E870-E879) is optional.
- Identical E-codes will not be accepted on the same inpatient discharge data record. This is consistent with the guidelines for E-codes in *Coding Clinic for ICD-9-CM*.
- If more than one drug or substance caused a poisoning or adverse effect, report all E-codes necessary to describe all substances.
- Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) must never be reported in the Other Diagnoses code fields. Such codes must only be reported in the External Cause of Injury code fields.

Principal E-code: The principal E-code is defined as the external cause of injury or poisoning which describes the mechanism that resulted in the most severe injury, poisoning, or adverse effect initially diagnosed and/or treated during the current inpatient admission. If sequencing the external cause of the most severe injury as the principal E-code is contradictory to the guidelines given in ICD-9-CM, OSHPD reporting requirements take precedence.

Other E-codes:

- Defined as additional ICD-9-CM codes from the range E800-E999 necessary to completely describe the mechanisms of injuries, poisonings, or adverse effects diagnosed and/or treated during the first inpatient admission.
- Include category E849 (place of occurrence) if documented in the medical record and not previously reported to OSHPD on a first inpatient admission.

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Place of occurrence codes (category E849) are:

- Invalid as the principal E-code.
- Reported to OSHPD if the principal E-code does not specify the place of occurrence.
- Reported to OSHPD as unspecified (E849.9) when the place of occurrence is not specified in the medical record.

Number of Other E-codes: Four other E-codes in addition to the principal E-code may be reported to OSHPD.

- If the reporting format limits the number of E-codes that can be used in reporting to OSHPD, refer to the Coding Clinic for ICD-9-CM for coding multiple E-codes in the same three-digit categories or different three-digit categories. In either case, include the place of occurrence E-code.